



LOS ANGELES COUNTY COMMISSION FOR CHILDREN AND FAMILIES

Kimberly A. Foster
Executive Director

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ADELINA SORKIN, LCSW/ACSW, VICE CHAIR
DR. HARRIETTE F. WILLIAMS
TRULA J. WORTHY-CLAYTON

APPROVED MINUTES

The General Meeting of the Commission for Children and Families was held on Monday, **April 16, 2007**, in room 739 of the Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles. **Please note that these minutes are intended as a summary and not as a verbatim transcription of events at this meeting.**

COMMISSIONERS PRESENT (Quorum Established)

Carol O. Biondi
Hon. Joyce Fahey
Ann E. Franzen
Susan F. Friedman
Rev. Cecil L. Murray
Sandra Rudnick
Adelina Sorkin
Dr. Harriette F. Williams
Trula J. Worthy-Clayton

COMMISSIONERS ABSENT (Excused/Unexcused)

Patricia Curry
Dr. La-Doris McClaney
Helen A. Kleinberg
Wendy L. Ramallo

APPROVAL OF AGENDA

The agenda for the April 16, 2007, meeting was unanimously approved.

APPROVAL OF MINUTES

The minutes of the April 2, 2007, general meeting were unanimously approved.

CHAIR'S REPORT

A letter to the Chief Administrative Office has been drafted protesting the decision to remove the Commission for Children and Families from the aegis of the Executive Office and place it in the Department of Children and Family Services budget. In commenting

on the draft, Commissioners agreed that stronger language was needed with regard to the Commission's effectiveness being compromised by the proposed new structure, and also with regard to avoiding the conflict of interest—apparent or actual—that exists when an independent body is funded through the agency it is designed to oversee. According to executive director Kim Foster, the Chief Administrative Office has no objection to the Commission's remaining with the Executive Office, but the current version of the county budget was printed before concerns were expressed. A reverse of the decision is planned during budget revision meetings in May.

Commissioner Biondi moved that the draft letter be revised to incorporate the Chief Administrative Office's commitment to reversing the decision, and to reiterate Commissioner concerns as expressed. Commissioner Williams seconded the motion, and it was unanimously approved.

DIRECTOR'S REPORT

DCFS director Trish Ploehn noted items on the April 17 Board of Supervisors agenda:

- Final approval for submitting the Title IV-E waiver plan to the state
- A report on the Adoption and Safe Families Act (ASFA) home inspections and the transfer of funds pending a plan from DCFS to conduct initial and annual ASFA assessments.
- Recommendation for the CAO to work with Casey Family Programs and Dr. David Sanders in developing a plan to bring Los Angeles County's health and human services agencies into alignment. CAO to report back in 90 days.
- Recommend for the CAO to draft a letter urging the House Subcommittee on Information Policy, Census and National Archives to restore the 'foster child' category to the 2010 census

Commissioner Williams asked for a detailed report on the ASFA process at the next meeting, which Ms. Ploehn promised.

MENTAL HEALTH SERVICES ACT: FULL-SERVICE PARTNERSHIPS (CHILDREN)

Paul McIver, acting Deputy Director of children's program administration for the Department of Mental Health, characterized the Mental Health Services Act as a tremendous opportunity to expand mental health services to children (birth to age 15), transition-age youth (age 16 to 25), adults (age 26 to 59), and older adults (60 and older) in new ways. Planning began even before voters passed Proposition 63, and community services and supports was the first component to be implemented.

Lisa Wicker from DMH reported that contracts for the majority of full-service partnerships have been finalized, and a list distributed to Commissioners showed the first-round agencies active (since mid-December or January) in SPAs 2, 3, 4, 5, and 8. The second

phase, incorporating SPAs 1, 6, and 7, is expected to be online in May. When the program is at full capacity, 1,733 full-service partnership slots will be available for children from birth to age 15. As of March 31, just under 1,100 slots were available, with 164 participants enrolled.

Children with serious emotional disturbances may be referred to full-service partnership slots if they:

- Are at high risk of expulsion from preschool
- Have been removed or are at high risk of removal from their homes by DCFS
- Have parents or caregivers with severe and persistent mental illnesses, substance abuse disorders, or co-occurring disorders
- Are in transition to a less restrictive placement
- Are experiencing suspension or expulsion from school, violent behaviors, drug possession or use, or suicidal or homicidal ideation
- Are involved with the Probation Department, on psychotropic medication, and transitioning into a less structured home or community setting

Most participants are new to the system, and the majority are Latino. 164 children are enrolled; 20 are age five and under, 7 are involved with Probation, and the remainder have exhibited severe behavioral problems at school, and are involved with or at risk of involvement with DCFS.

Referrals are initially made to the program through DMH's Impact Units, and are sent to the central administrative unit for final authorization within 48 hours. (Children with acute needs are immediately served by providers, who can open an outpatient case on the child while simultaneously making an urgent referral.) Approximately 80 percent of all referrals are authorized, DMH's Mary Silvestrini said; others may be returned for further information or do not meet the focal population guidelines. Referred families may also move or decline services. The administrative unit tracks data, geographically and by provider, on the focal population benchmarks developed by the MHSA stakeholder group during the planning process, as well as on ethnic targets established by DMH.

Providers conduct extensive outreach to consumers who have not traditionally accessed mental health services, and building trust in many of those communities will take time. The number of slots each agency offers is a balance between its capacity and the surrounding need, and contracts may be modified depending on enrollment.

Other full-service partnership services, available now or in the planning stages, include:

- Family support services such as counseling and other mental health services for parents and caregivers (including relative caregivers), peer support, transportation, and access to health care
- Respite care for caregivers experiencing significant stress that could result in out-of-home placement (administered by Pacific Clinics, to be available by May or June 2007)

- Services for co-occurring mental health and substance abuse disorders (to be available in August 2007 through an evidence-based training curriculum yet to be developed)

Each children's full-service partnership slot costs \$16,850 per year. Because most participants are eligible for Medi-Cal (which funds about 90 percent of the program's direct-service expenses), MHSA dollars are used only for the medically indigent and for family support and other indirect services. The percentage of MHSA monies directly funding other population segments, where other assistance streams are not as available, is higher.

In answer to a query from Commissioner Fahey with regard to ethnic targets, Ms. Wicker explained that the DMH planning division—and the 12,000 stakeholders involved in the MHSA planning process through community forums, work groups, and other meetings—examined many countywide factors in determining goals for MHSA implementation funds. The majority of funds are intended for individuals not traditionally part of the mental health system, such as Latinos, and those who are underrepresented within it. Rather than leaving their access to chance, planners established specific goals for ethnic group participation, a practice not followed by other programs. (Medi-Cal, for instance, is open to anyone within certain income eligibility limits, or with an identified disability.)

The mere passage of the MHSA did not automatically mean an influx of capable professionals, of course, and full-service partnership contracts specify required licensures and the employment of consumers to engage participants and deliver some peer-to-peer services. The shortage of child psychiatrists, nurses, psychologists, and other professionals is a statewide and nationwide concern, and workforce development—including tuition help for students willing to make a reciprocal commitment to public service, publicized through the universities—is another component of MHSA planning, along with information technology and innovation.

Commissioner Biondi expressed concerns about the exclusion of youth in the Juvenile Justice system from the draft guidelines for the MHSA's prevention and early intervention component. Young people (birth to age 25) are eligible only if they are at risk of entering that system, whereas adults at risk of incarceration or already incarcerated are both eligible. In addition, the proportion of prevention and early intervention monies available for youth 25 and under has recently been reduced from 75 percent to 51 percent, even though it would seem obvious that prevention efforts are most effective with children and transition-age youth. That decision came out of negotiation meetings with the Mental Health Services Oversight and Accountability Commission that have taken place over the last few months, Mr. McIver said, and are meant to ensure community input. Commissioner Sorkin stated that she attended a stakeholder meeting at the beginning of the process and found the proceedings dominated by adult advocates; with few child advocates present; who seemed to feel that children have many other sources of funds available to them, and therefore don't need the MHSA monies. It is the county's responsibility to provide mental health services to juveniles in its care, Commissioner

Biondi maintained, but it is not doing so. This new money ought to serve children who need these interventions.

Dan Thorne from Harbor View's Children's facility in Long Beach informed the Commission that the facility has been offering field-based mental health services for 10 years in that community. Its full-service partnership contract began late last year, and 15 clients are currently in different phases of the process. Six are enrolled, four are in the outreach and engagement stage (pre-authorized for participation by the county and deciding about participation in the program), and five are awaiting pre-authorization. (Another client has declined services.) Of the six who are enrolled, three are African-American and three are Latino; their ages range from 8 to 14 years, and they all fall into the 'underserved' category.

Harbor View enjoys a close relationship with the Long Beach Unified School District (10 clients were referred by their schools), and is working hard with county and community agencies to give talks about the program and engage individuals unfamiliar with the mental health system. Commissioner Fahey suggested contacting the commissioner at the informal juvenile court at the Long Beach courthouse as well.

With the 'whatever it takes' approach common to full-service partnerships, Harbor View is having to address many non-therapeutic issues that are preventing families from coping—bills, legal matters, and housing among them—and is doing far more than simply providing counseling. For children suspended from school, for example, the agency offers tutoring and coaching services to continue student engagement in education. Medication support is available through a psychiatrist who follows DCFS protocols for court authorization and auditing, thoroughly discusses the medication and its side effects with families, and monitors compliance and results closely. Connections for other services are made through relationships with other agencies in the area and through Harbor View's other programs. Challenges for the agency include:

- Housing
- A lack of mentoring and training programs (Harbor View is partnering with other agencies and creating services of its own)
- Recruiting, given the current high demand and low supply of qualified staff
- Finding parent partners and advocates for consumer involvement

Ed Shrader, Clinical Director at Almansor Clinical Services, which has offered outpatient services in the East and West San Gabriel Valley (SPA 3) for 17 years. For its full-service partnership clients, Almansor makes only medical support available at its clinic, providing other services at the child's home or school—it works with five school districts and 45 public schools—which decreases stigma and transportation issues. It uses two bilingual treatment teams, including two psychiatrists, and would like to expand into SPA 7 and the Montebello school district.

Since its contract began in January 2007, 20 clients, half male and half female, have enrolled in Almansor's 30 slots; 25 cases have been referred, but some families have

refused to enter the program, though they are still engaged with the agency. Five clients are age five and under, with the remainder age six through 15. Seventeen clients have issues with aggression, and eight are dealing with homelessness. Eighteen of the 20 clients are Latino, reflecting the high numbers of Latinos in the area's school districts, and 12 of those families prefer to receive services in Spanish. Homelessness, substance abuse, and domestic violence all affect client families, and Almansor is using some full-service partnership funds to pay for housing.

MENTAL HEALTH SERVICES ACT: TRANSITION-AGE YOUTH SERVICES

Terri Boykins from the Department of Mental Health distributed a packet of information on MHSA services for transition-age youth (TAY), 16 to 25 years old. Much of the TAY full-service partnership program is similar to the one for children, including the authorization process, but the TAY program focuses on:

- Homeless youth or youth at risk of homelessness
- Youth aging out of the child mental health, child welfare, or juvenile justice systems
- Youth leaving long-term institutional care, including state hospitals, probation camps (or any kind of detention), RCL level 12–14 group homes, community treatment facilities, and institutions of mental disease
- Youth experiencing their first psychotic break
- Youth with co-occurring substance abuse disorders, along with any of the above

As of the end of March, 137 youth have been enrolled in the 708 full-service partnership slots in SPAs 2, 3, 4, 5, and 8. Contract negotiations are in process with providers in SPAs 1, 6, and 7, and 390 additional slots in those areas should begin rolling out in May or June. An ethnic breakdown of participants will be provided to Commissioners once it is compiled. A brochures about the TAY full-service partnerships has been translated into 11 languages and will be distributed widely.

Ms. Boykins expressed appreciation to Commissioners Biondi and Curry, and to Kathy House in the Chief Administrative Office's Service Integration Bureau, for their support in creating the DMH TAY division. Challenges for the overall program include:

- Recruitment for staff who can meet the TAY population's unique needs, both in provider agencies and in the new TAY division
- Doing new things in different ways within the county bureaucracy
- Leveraging resources through existing pots of money
- Housing

Housing in particular is a major magnet for referrals to TAY full-service partnerships, Ms. Boykins said, especially with its high cost in Los Angeles. Severely mentally ill youth often are not ready to live as independently as they would like, but most are not interested in adult board and care facilities, and some need residential drug treatment settings. Judges will not order the release of transition-age youth housed in adult jails, either, until post-incarceration services are identified. Few resources exist for youth not

eligible for independent living program subsidies and assistance, and collaborations with other agencies are necessary to find options for them.

Ms. Boykins estimated that between 40 and 45 percent of the overall TAY full-service partnership funding comes from MHSA dollars, which fully pays for the 35 percent of slots reserved for youth uninsured (through Medi-Cal or SSI) at the time of their enrollment. She will inquire of her staff tomorrow about the reduction in planned prevention and early intervention funds available to children and youth.

In addition to the full-service partnerships, the TAY division is also planning two drop-in centers where youth can find safety and build relationships with staff who can connect them with services and supports. The four proposals received for these centers are being scored now, with a target implementation date of July 2007. Coordination with the existing independent living program drop-in centers was not mentioned in the centers' Request for Services, but details on collaborative partnerships were required. MHSA monies will also fund services in the probation camps as well as further housing services, including housing specialists, emergency vouchers for shelter beds, and \$390,000 in project-based subsidies.

Dr. Gina Perez, Pacific Clinic, oversees TAY full-service partnerships in SPAs 2, 3, 4, and 7, which specializes in younger transition-age youth, from 16 to 21 years. In SPA 3, 64 percent of the agency's 47 available slots have been filled, mostly with Latino clients, some African-Americans, and a few whites. Pacific Clinics also has 25 additional TAY slots identified specifically for the Asian/Pacific Islander population.

As an example of the work Pacific Clinics has done with similar at-risk youth, Dr. Perez reviewed results from a street outreach project funded in 2004 by The California Endowment that sent two outreach workers in a van into the East San Gabriel Valley. Over a period of two years, the team—former foster and probation youth themselves, and in recovery from substance abuse—made contact with homeless youth in parks, recreation facilities, video arcades, and elsewhere, doing community outreach with medical clinics, probation, DCFS, the courts, and so on. Because of its background and approach, the team developed a reputation for trustworthiness, and eventually was able to engage 327 youth, half male and half female, in various forms of treatment. (Two-thirds had not been in foster care and were therefore not eligible for independent living resources—similar to what is being found with full-service partnership clients.)

Of the youth engaged through the Healthy Transitions program who responded to a follow-up survey:

- Sixty-five percent had been medically uninsured at the point of contact; 14 percent were subsequently linked to benefits.
- Twenty percent were on probation; criminal record clearances reduced that to 8.2 percent.

- All had mental health issues, including depression, anxiety, and bipolar disorders; following treatment, suicidal ideation decreased from 33 percent to 2 percent and feelings of sadness and hopelessness reduced from 80 percent to 12 percent.
- Use of marijuana fell from 81 percent to 25 percent, alcohol use from 81 percent to 27 percent, and methamphetamine use from 45 percent to 6 percent. (Though this was self-reported, Dr. Perez feels it is a fairly accurate assessment.)
- Fifty-five percent are now employed and 51 percent are enrolled in an education program. Dr. Perez feels that this figure, too, may have slipped by only a little.
- All are off the streets (as opposed to 64 percent of the initial total who had no home), living with family and friends, in transitional housing, in residential substance abuse facilities, or independently.

Jack Avila from the Hillview agency in SPA 2—which specializes in the older TAY population—said that 18 of its 40 full-service partnership slots had been filled with 12 males and 6 females, 12 of whom had been facing homelessness as a result of being released from a jail or hospital setting. Four clients had been diagnosed with paranoid schizophrenia and were selectively mute, which required repeated visits to the hospital before they could consent to treatment (all are now speaking). Two had been housed in a 20-bed youth facility at Hillview Village, are extremely disabled, and need constant supervision and medication monitoring. Most referred youth are over 18 and uninsured, and only one had SSI or Medi-Cal at enrollment, being under 18.

Hillview offers crisis management, psychiatric management, therapy, transportation, and individual and group therapy for co-occurring disorders, but the biggest issue it faces is housing. Because of their substance abuse, clients are often abandoned by family and other caregivers, and even former foster youth may not have participated in independent living programs that offer housing assistance. Without help, most will face homelessness.

A \$3.5 million homeless prevention initiative for the transition-age youth population is part of the county's Homeless and Housing Program, Kathy House said, and needs to connect with the independent living program. A new housing coordinator position is now beginning to look at all the different funding sources for housing and how to leverage them. Camps Scott and Scudder have received the bulk of the funds earmarked for probation youth emancipating from non-foster care situations, and that program is rolling out.

PUBLIC COMMENT

Michelle McKinney from Public Counsel emphasized the importance of accessibility for youth trying to self-refer for homelessness, stating that it's often difficult for youth to make connections without an advocate. Systems navigators in the field, Ms. Boykins said, can provide access to assessments and full-service partnerships, and the web is constantly expanding. She suggested that youth contact any of the staff listed on the contact sheet distributed, and said that the planned drop-in centers would be another component in ensuring access, as is provider outreach to school districts.

Ms. McKinney also recommended an educational component for homeless youth to demystify the stigma of mental illness so they can learn the warning signs before they are

in crisis. Educating the public on these issues is on the DMH agenda, Ms. Boykins assured her, and a planning process is in place.

OLD BUSINESS, AND EXECUTIVE DIRECTORS REPORT

Tabled for next Commission meeting.

ADJOURNED